

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tarpan papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last James Monroe Austin					2a. DATE OF DEATH Month Day Year 1 11 69			2b. HOUR 8:30am	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1-1-77 ?		6. AGE (In years last birthday) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) USA, Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Co. Md.			
10. CITY OR TOWN OF DEATH Sykesville, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Butcher		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montg. Co.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 445	
14. FATHER'S NAME First Middle Last William Austin			15. MOTHER'S MAIDEN NAME First Middle Last Jenney ? ?						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes, give way or dates of service) Yes World War I		16b. SOCIAL SECURITY NO. 265-22-29749		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>4123</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Arteriosclerotic heart disease</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>years</u> <u>years</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>CBS associated with cerebral arteriosclerosis with psychotic reaction</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (X) (this hospital) attended the deceased from <u>5-18-</u> , 19 <u>65</u> , to <u>1-11-</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>01/11/</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Moises Sucholeiki M.D.</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>1-11-69</u>			
22d. PHYSICIAN'S NAME (Type) Moises Sucholeiki, M. D.				22e. ADDRESS Springfield State Hospital, Sykes, Md.					
23a. BURIAL CREMATION, (REMOVAL) (Specify) <u>REMOVAL</u>		23b. DATE <u>1-14-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ANAT. GUARD U. of M.</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MD.</u>			
24. FUNERAL DIRECTOR <u>David Funeral Home</u>				ADDRESS <u>1616 N. E. St.</u>		25a. REC'D BY REGISTRAR <u>16 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



0430



1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 416 M
304 REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00650					00645				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
THEODORE (NMN) BAMBERGER					JANUARY 24, 1969			5:40 A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR	
Male		White		7-20-08		60 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Carroll Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Sykesville		Springfield State Hospital		Machine Operator		Meat Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Baltimore City		Baltimore				3112 Keswick Rd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Henry Bamberger			Frances Lipki						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
National Guard			217-09-2995		Records, Springfield State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease									
4124 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION		City or Town County State		
					Street or R.F.D. No.				
22a. I certify that (I) (this hospital) attended the deceased from 4-22-68, 19__, to 1-24-69, 19__, that (I) (we) last saw the deceased alive on 1-24-69, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
Octavio A. Ruiz, M.D.					1-24-69				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Octavio A. Ruiz, M. D.					Springfield State Hospital Sykesville, Maryland 21784				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1-27-1969		Oak Lawn Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
George J. Gonce, 4001 Ritchie Hwy., Baltimore					DATE JAN 29 1969		J. Charles Judge		

08282

ESTATE OF DEATH

08282



08282

ESTATE OF DEATH

08282

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-11-68
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00651	00646				
1. DECEASED-NAME (Type or print)							2a. DATE OF DEATH			2b. HOUR					
First		Middle		Last			Month		Day		Year		Hour		
CHARLES		B.		BARNES			1		13		69		5 ¹⁰ P M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS		IF UNDER 24 HRS. HOURS		
Male		White		Aug. 20, 1893			75								
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH								
Maryland		U.S.A.					Carroll Md								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY							
Westminster		Carroll Co. Gen. Hospital			Carpenter-retired										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER							
Maryland		Carroll		Finksburg				R.D. 2							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last	
Lloyd		G.		Barnes				Ida		Williams					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes, give year and dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address									
yes		WW I		213-18-8802		Mrs. Kathryn A. Barnes Same As #13.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATHEROSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4/23 YEARS</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>PULMONARY EMPHYSEMA</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/28, 1968</u> , to <u>1/13, 1969</u> , that (I) (we) last saw the deceased alive on <u>1/13, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Vincent J. Fiocco</u>						22c. DATE SIGNED <u>1/13/69</u>		22d. PHYSICIAN'S NAME (Type) <u>Vincent J. Fiocco</u>							
22e. ADDRESS <u>Westminster, Md.</u>															
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)		(County)		(State)			
Burial		1-16-1969		Mt. Pleasant Cemetery				Gamber, Carroll		Md.					
24. FUNERAL DIRECTOR ADDRESS <u>C. M. Waltz, Box 241, Sykesville, Md.</u>						25a. REC'D BY REGISTRAR <u>JAN 16 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

34880

RECEIVED

8809

8809

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00652									
00647									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
RHODA			ANNA			BARNES			12:05 P
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
FEMALE	WHITE		NOV. 18, 1894		74 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				CARROLL CO.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
WESTMINSTER		CARROLL CO. GEN. HOSP.			CLERK, TELEPHONE CO.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		CARROLL		WESTMINSTER				70 W. GREEN ST.	
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last
WILLIAM ODEN BARNES						MARGARET N. RIDINGER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
			212-10-0032-A			J. GAROLD BARNES			14 GIST ROAD WESTMINSTER MD
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cerebral ischemia									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Hypotension									
DUE TO, OR AS A CONSEQUENCE OF									
(c) Acute myocardial Infarction.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Chronic obesity									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Spring, 1968, to Jan 20, 1969, that (I) (we) last saw the deceased alive on Jan 20, 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
William R. Bourke MD DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			Jan 20/69	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		1/23/69		BETHEL CEMETERY		NEW WINDSOR, CARROLL MD			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
X. S. Murre, Jr. Westminster, Md					JAN 22 1969		J. Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-5 (4)
30M REV 7-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
Pearl			V. Becraft			Month 1 Day 24 Year 69		8 a M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female		White		Aug. 25, 1897		71 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Carroll Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Woodbine			Box 25			Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Carroll		Woodbine		X		Box 25	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
George A. Green			Margaret Hatfield							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			215-20-7784		Norman A. Becraft, Sr. Same As #13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent coronary occlusion</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF <u>presented as</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infarction of myocardium: pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive ASCVD</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>2 yrs.</u> <u>10 yrs.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Heart failure, Diabetes mellitus</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 13, 1966</u> , to <u>Jan. 24, 1969</u> , that (I) (we) last saw the deceased alive on <u>Aug. 13, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Sani Okutman, M.D.</u>					22c. DATE SIGNED <u>1/24/69</u>					
22d. PHYSICIAN'S NAME (Type) <u>Sani Okutman, M.D.</u>					22e. ADDRESS <u>Obrecht Rd., Sykesville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		1/27/1969		Lakeview Memorial Gardens		Carroll Co., Md.				
24. FUNERAL DIRECTOR ADDRESS <u>C. M. Waltz, Box 241, Sykesville, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>JAN 28 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

[Faint, mostly illegible text covering the main body of the page, possibly a letter or report.]

[Faint vertical text on the right margin, possibly a reference or filing note.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) JAMES Clayton Bloom			2a. DATE OF DEATH Month JAN Day 3 Year 1969			2b. HOUR 6:45 P					
3. SEX MALE		4. RACE white		5. DATE OF BIRTH June 5, 1884		6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md.					
10. CITY OR TOWN OF DEATH Uniontown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Construction			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) foreman			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD.			13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 85 W. Main St.		
14. FATHER'S NAME First Granville Middle Bloom Last Bloom			15. MOTHER'S MAIDEN NAME First Mary Middle WEBSTER Last WEBSTER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 214-01-0666		17. INFORMANT Raymond D Bloom, Jr. Address Uniontown Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Bladder (Transitional Cell) 188X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 160 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July 4 , 19 66 , to JAN , 19 69 , that (I) (we) last saw the deceased alive on Dec 15 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dean H. Griffin, M.D. M.D. DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 3 JAN 69		
22d. PHYSICIAN'S NAME (Type) DEAN H. GRIFFIN, M.D.						22e. ADDRESS 12 Ridge Rd. Westminster, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 1/6/68		23c. NAME OF CEMETERY OR CREMATORY MEADOW BRANCH			23d. LOCATION (City or Town) (County) (State) WESTMINSTER CARROLL MD			
24. FUNERAL DIRECTOR J. S. Myers, Jr. Westminster, Md.						25a. REC'D BY REGISTRAR DATE JAN 7 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references. The conclusion summarizes the main findings of the study and provides a final statement on the project. The references list the sources of information used in the study.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
EVA				JANET	BOLLINGER	Month Day Year JAN 12 69			5 A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE		WHITE		OCT. 15, 1921		47 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				CARROLL CO. Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
FINKSBURG RD #2		NEAR GAMBER		HOUSE-WIFE, STATE HOSPT. WORKER					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		CARROLL		FINKSBURG				RD # 2	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
JOSHUA L. BARNES						MAUDE J. BARNES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
NO			217-1814-09		WILLIAM E. BOLLINGER		SAME ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) HYPERTENSIVE CARDIOVASCULAR DIS. 4 YEARS PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from NOV 1957, to JAN 12 1969, that (I) (we) last saw the deceased alive on JAN 12 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Daniel I. Welliver				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-12-69	
22d. PHYSICIAN'S NAME (Type) DANIEL I. WELLIVER				22e. ADDRESS 19 RIDGE ROAD WESTMINSTER MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
BURIAL		1/15/69		PROVIDENCE CEMETERY		FINKSBURG RD #2 MD.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
J. S. Myers Jr., Westminster, Md.						JAN 15 1969		Charles Judge	

00358

MADE IN GERMANY

00358

MADE IN GERMANY

MADE IN GERMANY

MADE IN GERMANY

MADE IN GERMANY

MADE IN GERMANY

MADE IN GERMANY

MADE IN GERMANY

MADE IN GERMANY

MADE IN GERMANY

MADE IN GERMANY

MADE IN GERMANY

MADE IN GERMANY

MADE IN GERMANY

MADE IN GERMANY

MADE IN GERMANY

MADE IN GERMANY

MADE IN GERMANY

MADE IN GERMANY

MADE IN GERMANY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00656

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00651

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) HILDA NAOMI BOLLINGER			2a. DATE OF DEATH Jan Month 11 Day 1969 Year			2b. HOUR 4:18 M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JULY 1, 1900		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL CO. Md.			
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL CO. GEN HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SALES CLERK			12b. KIND OF BUSINESS OR INDUSTRY STORE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 139 BOND ST.	
14. FATHER'S NAME First SAMUEL Middle BEAM Last			15. MOTHER'S MAIDEN NAME First OLA Middle RAVER Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 220-34-6605		17. INFORMANT HARRY E. BOLLINGER			Address 55 CAMORE ST. WESTMINSTER, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 191X DUE TO, OR AS A CONSEQUENCE OF Brain tumor (astrocytoma) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Brain tumor (astrocytoma) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1969 , to Jan 11, 1969 , that (I) (we) last saw the deceased alive on Jan 11, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John S. Harshey, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/11/69			
22d. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY M.D.				22e. ADDRESS 8 Anchor St. Westminster, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1/15/69		23c. NAME OF CEMETERY OR CREMATORY MEADOW BRANCH		23d. LOCATION (City or Town) (County) (State) WESTMINSTER CARROLL CO. MD.			
24. FUNERAL DIRECTOR J. S. Myers Jr., Westminster, Md.				25a. REC'D BY REGISTRAR JAN 15 1969		25b. REGISTRAR'S SIGNATURE John S. Harshey			

UNITED STATES

REPORT OF THE
COMMISSIONER OF THE
BUREAU OF REVENUE
FOR THE YEAR
ENDING DECEMBER
31, 1900
PART I
GENERAL STATEMENT
OF THE REVENUE
FOR THE YEAR
ENDING DECEMBER
31, 1900

THE REVENUE
FOR THE YEAR
ENDING DECEMBER
31, 1900
WAS \$1,000,000,000
AS COMPARED WITH
\$900,000,000 IN
1899
AND \$800,000,000
IN 1900

THE REVENUE
FOR THE YEAR
ENDING DECEMBER
31, 1900
WAS \$1,000,000,000
AS COMPARED WITH
\$900,000,000 IN
1899
AND \$800,000,000
IN 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
EVA		M.		BONNER	Month	Day	Year	8:45 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE		MARCH 21, 1890		78 YRS.		MONTHS	DAYS	HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				CARROLL CO. Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
WESTMINSTER		CARROLL CO. GEN. HOSP.		HOUSE-WIFE AND MGR. OF CAFETERIA					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		CARROLL		WESTMINSTER				19 CHASE ST.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT	
JOSEPH		ANNIE				217-28-2218		MRS. BLANCHE BROTHERS, WESTMINSTER, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 437.9 CEREBRAL VASCULAR INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
BRONCHO PNEUMONIA									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	
		HOUR A.M. Month Day Year P.M. 19				While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 12/23, 1968, to 1/23, 1969, that (I) (we) lost saw the deceased alive on 1/23, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS	
		J. S. Murrin, M.D.		1/23/69					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		23e. REG'D BY REGISTRAR	
BURIAL		1/26/69		PROVIDENCE CEMETERY		GAMBER, CARROLL CO. MD.		JAN 27 1969	
24. FUNERAL DIRECTOR		24a. ADDRESS		24b. REG'D BY REGISTRAR		24c. REG'D BY REGISTRAR		24d. REG'D BY REGISTRAR	
J. S. Murrin, Westminister, Md. 2157									

1000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00653										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00653									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Middle Last Noah W. Bosley										Month Day Year 1 22 69										1 55 PM									
3. SEX Male			4. RACE White			5. DATE OF BIRTH Sept. 7, 1897			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN														
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll						Md.														
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER																	
Md.			Carroll			Hampstead						36 N. Main St.																	
14. FATHER'S NAME First Middle Last Noah A. Bosley					15. MOTHER'S MAIDEN NAME First Middle Last Violet Harriss																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO. (If yes give war or dates of service)					17. INFORMANT Address Mrs. William Frederick Hampstead, Md.																			
NO					219-12-2252																								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATHEROSCLEROTIC VASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>YEARS</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>PNEUMONITIS</u>																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from <u>1/21</u> , 19 <u>69</u> , to <u>1/22</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/22</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>Vincent J. Kroenig MD</u>					22c. DATE SIGNED <u>1/22/69</u>					22d. PHYSICIAN'S NAME (Type)																			
22e. ADDRESS																													
23a. BURIAL, CREMATION, BURNING (Specify)			23b. DATE Jan. 24, 1969			23c. NAME OF CEMETERY OR CREMATORY Hampstead Cemetery			23d. LOCATION (City or Town) (County) (State) Hampstead Carroll Co. Md.																				
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md.					25a. BY REGISTRATION DATE JAN 27 1969					25b. REGISTERED JUDGE																			

John A. Hoxby

John

April 1, 1907

John

John

Carroll Co. House, Carroll Co. House, Carroll Co. House

Carroll Co. House

Carroll Co. House, Carroll Co. House, Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

Carroll Co. House

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

00659

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00654

1. DECEASED NAME (Type or print) Harry		First Stouffer		Last Brewer		2a. DATE OF DEATH January 25, 1969		Month Day Year		2b. HOUR 8:30 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 4-14-02		6. AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll County, Md.					
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mathematician		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Funkstown			
14. FATHER'S NAME First Middle Last Frank R. Brewer				15. MOTHER'S MAIDEN NAME First Middle Last Minie Stouffer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service) None		16b. SOCIAL SECURITY NO. 219-05-2146T		17. INFORMANT Address Records, Springfield State Hospital							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive hemorrhage 531.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Erosion of blood vessel in the floor of large gastric ulcer DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 12-23-1948 , to 1-25-1969 , that (I) (we) last saw the deceased alive on 1-25-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Octavio A. Ruiz, M.D.		DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-27-69					
22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.		22e. ADDRESS Springfield State Hospital									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/29/69		23c. NAME OF CEMETERY OR CREMATORY Funktown Cemetery		23d. LOCATION (City or Town) (County) (State) Funktown Wash Co Md					
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc		ADDRESS Hagerstown Md		25a. RECEIVED BY REGISTRAR JAN 30 1969		25b. REGISTRAR'S SIGNATURE [Signature]					

000000

000000

000000

000000

000000

000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

00669

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00655

1. DECEASED-NAME (Type or print) Beatrice Maude Brundage			2a. DATE OF DEATH 1 Month 17 Day 69 Year			2b. HOUR 1:45 am			
3. SEX female		4. RACE white		5. DATE OF BIRTH 10/17/78		6. AGE (In years last birthday) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) England		7b. CITIZEN OF WHAT COUNTRY? England U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Rural--Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) saleslady		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2318 Cloville Avenue	
14. FATHER'S NAME First Middle Last ? Napper			15. MOTHER'S MAIDEN NAME First Middle Last ? Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 213-10-5190		17. INFORMANT Address Springfield Hospital records, Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Broncho Pneumonia 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic brain syndrome associated with cerebral arteriosclerosis with behavioral reaction.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that he (this hospital) attended the deceased from 1/29/1968 , to 1/17/1969 , that he (we) last saw the deceased alive on 1/17/1969 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Glocrite G. Sagisi</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/17/69			
22d. PHYSICIAN'S NAME (Type) Glocrite G. Sagisi, M.D.				22e. ADDRESS Springfield State Hospital Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/20/69		23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Maryland				25a. REC'D BY REGISTRAR JAN 20 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

00882

UNITED STATES OF AMERICA

1000000000

DATE: 10/10/62

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12
30
4

2

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		
Theckla			nmn		BURGESS				January 17, 1969		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7b. IF UNDER 1 YEAR MONTHS DAYS		
female		white		8-26-91 92			76 YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
New York			U.S.A.				Carroll Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			Springfield State Hospital			Saleslady					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland					Balto. 21219				4902 Greenspring Avenue		
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		
Joseph			Iasuer						Victoria Iasuer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
no			217-20-8306		Records - Springfield State Hospital						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Myocardial infarction.											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) Coronary heart disease.											
DUE TO, OR AS A CONSEQUENCE OF											
(c) Arteriosclerosis.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
CBS assoc. with cerebral arteriosclerosis with psychotic reaction.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12-6-63, 19__, to 1-17-69, 19__, that (I) (we) last saw the deceased alive on 1-17-69, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
MARIO E. COMAS			Springfield State Hospital Sykesville, Maryland 21784								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
			1/18/69		Moreland Memorial			Baltimore Baltimore Md.			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Wm Cook-Brooks Inc. 1050 York Rd. Towson						JAN 21 1969		John C. Judge			

35300

RECEIVED

300

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00662

CERTIFICATE OF DEATH

00657

1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR	
EDWARD			JONES	BUTLER		Month	Day	Year	1:15 M	
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR	
Male			White		10/24/81		87 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Carroll Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Sykesville			Springfield State Hosp.			Painter				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			V.		Balto. City		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5328 Cordelia Ave.	
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle
CHARLES			E.	BUTLER		AGNES			MARTHA	JONES
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
no			220-07-0214		Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>										days
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterioneurophrosclerosis - uremia</u>										months
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arter osclerosis</u>										years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>CBS assoc. with arteriosclerosis (cerebral), with psychotic reaction</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 18, 19 68</u> to <u>01/06</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>01/06</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE			22c. DATE SIGNED							
<u>Suha Ozgun.</u>			1/06/69							
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS							
<u>Suha Ozgun, M.D.</u>			<u>Springfield State Hosp., Sykes., Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
<u>Burial</u>		<u>Jan. 10, 1969</u>		<u>Cemetery Pleasant Grove, Boring, Md.</u>		<u>Boring, Maryland</u>				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<u>Eugenia K. Seitz 5209 York Rd. Balto. Md. 21212</u> <u>Seitz Funeral Home</u>						<u>JAN 8 1969</u>		<u>Charles Young</u>		

73800

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

TO THE SECRETARY OF AGRICULTURE
FROM THE DIRECTOR OF THE BUREAU OF PLANT INDUSTRY
SUBJECT: [Illegible]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00663		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00658	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) Bessie P. Carlyle			First Middle Last		2a. DATE OF DEATH Month 1 Day 6 Year 69		2b. HOUR 10a
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MARCH 26 1902		6. AGE (In years last birthday) 66 YRS.	
7a. BIRTHPLACE (State or foreign country) N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL	
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Waite Ave.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md.		13b. COUNTY CARROLL		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Waite Ave.		14. FATHER'S NAME First JORDON - Middle BUNN Last BUNN		15. MOTHER'S MAIDEN NAME First Katie - Middle Williams Last Williams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 242 14 4112		17. INFORMANT MR. DWIGHT CARLYLE		Address Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent Cerebral Hemorrhage 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetic ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) Diabetic Mellitus							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 10 yrs. 15 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Flu							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Dec. 17, 1960 , to Jan. 2, 1969 , that (I) (we) lost saw the deceased alive on Jan. 2, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Sani Okutman				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/7/69	
22d. PHYSICIAN'S NAME (Type) Sani Okutman, M.D.				22e. ADDRESS Obrecht Rd., Sykesville, Md. 21784			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-9-69		23c. NAME OF CEMETERY OR CREMATORY New oakland cemetery		23d. LOCATION (City or Town) (County) (State) Sykesville, Md.	
24. FUNERAL DIRECTOR Harry W. Haight				ADDRESS Sykesville, Md.		25a. RECD BY REGISTRAR JAN 10 1969	
						25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00664		CERTIFICATE OF DEATH						00659			
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH	2b. HOUR	
Susan			-		Caston				1 Month 29 Day 69 Year	1:55 am	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
female		white		6/25/81			87 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Maryland		USA					Carroll Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Rural--Sykesville			Springfield State Hospital			housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.			Frederick		Myersville				Coxey Brown Road		
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		
James			Quincy		Lucie		Wright				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) no			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
			unknown		Springfield Hospital records, Sykesville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u>											
4123 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>										years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic brain syndrome associated with senile brain disease with behavioral reaction.</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that he (this hospital) attended the deceased from <u>10/16/1968</u> , to <u>1/29/1969</u> , that he (we) lost saw the deceased alive on <u>1/29/1969</u> , and that in our (our) opinion death occurred on the date and hour and from the causes stated above, or (we) (did) not view the body after death.											
22b. SIGNATURE <u>Bracito W. Patrício, M.D.</u>			22c. DATE SIGNED <u>1/29/69</u>			22d. PHYSICIAN'S NAME (Type) <u>Bracito W. Patrício, M.D.</u>					
22e. ADDRESS <u>Springfield State Hospital</u>			22f. ADDRESS <u>Sykesville, Maryland</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			2-1-1969		Harmony			Nr. Myersville, Fred. Co. Md.			
24. FUNERAL DIRECTOR <u>Paul F. Bittle</u>			ADDRESS <u>Myersville, Md.</u>			25a. REC'D BY REGISTRAR <u>JAN 31 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

LORDS

JUDGES

OF THE

COURT

OF COMMONS

OF THE

COURT

OF COMMONS

OF THE

COURT

OF COMMONS

OF THE

COURT

OF COMMONS

OF THE

COURT

OF COMMONS

OF THE

COURT

OF COMMONS

OF THE

COURT

OF COMMONS

OF THE

COURT

OF COMMONS

OF THE

COURT

OF COMMONS

OF THE

COURT

OF COMMONS

OF THE

COURT

OF COMMONS

OF THE

COURT

OF COMMONS

OF THE

COURT

OF COMMONS

OF THE

COURT

OF COMMONS

OF THE

COURT

OF COMMONS

OF THE

COURT

OF COMMONS

OF THE

COURT

OF COMMONS

OF THE

COURT

OF COMMONS

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

60
06

Bp 2

00665

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00660

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED		Month		Day		Year		2b. HOUR									
JULIA		C.		CHINLAW				Jan. 19,		169		6:31		P											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS		MIN.		7c. DATE PRONOUNCED DEAD Month		Day		Year		1969		6:31		P	
Female		White		Nov. 23, 1904		64 YRS.								Jan.		19,		1969		6:31		P			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. COUNTY OF DEATH												Md.	
MD.		U.S.A.										Carroll													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY																			
Westminster		Carroll County General																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER																	
Maryland		Carroll		Westminster		YES <input type="checkbox"/> NO <input type="checkbox"/>		15 S. Tremont Rd.																	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last											
JOHN		MACKESSY						NETTIE						HALL											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS																			
No		219-28-7377		Raymond A. Mackessy		204 E. Barney St.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
4124		DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF																					
		(c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State															
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 1/20/69											
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)															
Burial		11-23-69		Baltimore National Cemetery		Baltimore		Md.																	
24. FUNERAL DIRECTOR		ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																			
Forley, Cunningham F.H.		Catonsville, Md.		22-1969		Judge																			

03300

WORLD EXHIBITION, CHICAGO, 1893

00000

1893

HEALTH DEPT

1893

1893

1893

1893

1893

1893

1893

1893

1893

1893

1893

1893

1893

1893

1893

1893

1893

1893

1893

03300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR
Frieda			B.		COHEN	January 10, 1969			7:10p M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
female		white				73		YRS. MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Carroll Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Sykesville		Springfield State Hospital		Office work (retired)		GOVERNMENT			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3706 Dorchester Rd.	
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			
Moses Cohen						Rebecca Wender			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT					
no				MR. MEYER COHEN, 6310 GREENSPRING AVE, APT. 201					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Uremia</u>								days	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>CBS assoc. with cerebral arteriosclerosis with psychotic reaction.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <u>3-11-63</u> , 19 <u> </u> , to <u>1-10-69</u> , 19 <u> </u> , that (X) (we) lost saw the deceased alive on <u>1-10-69</u> , 19 <u> </u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
<u>Arnold Melman, M.D.</u>								1/10/69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS		22f. ADDRESS			
Arnold Melman, M.D.				Springfield State Hospital		Sykesville, Maryland 21784			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		1-12-69		BETH EL		RANDALLSTOWN, MARYLAND			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD						JAN 15 1969			

13300

CRIMINAL RECORDS

13300

13300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Lydia				Good	Crawmer.	Jan 19 1969			11A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS.
Female		white		Jan 26, 1886		82 YRS.		MONTHS	HOURS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Carroll Co		USA-				Carroll.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Manchester, Md.			128 W Main St - Longview Nursing Home			Nurse			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Carroll.		Westminster			29 Webster St	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
John					Crawmer.	Mary Elizabeth			Mallick
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No			220-10-5641		Nellie Lawrence, Furlong Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) 4123 Arteriosclerotic Heart Disease									5 yrs
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No.					
22a. I certify that (I) (this hospital) attended the deceased from 4/1, 1968, to 1/19, 1969, that (I) (we) last saw the deceased alive on 1/17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		W.H. Foard M.D		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
								1/19/69	
22d. PHYSICIAN'S NAME (Type)		W.H. Foard M.D		22e. ADDRESS		25 W Main St			
						MANCHESTER, MD 21102			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		Jan 22, 1969		Meadow Branch Cemetery		Westminster		Carroll Md.	
24. FUNERAL DIRECTOR		25. ADDRESS		26. PREPARED BY		27. REGISTERED		28. REGISTERED	
Thomas D. Fletcher		254 E. Main St.		JAN 24 1969					
Thomas D. Fletcher Funeral Home		Westminster Md		DATE					

00000

00000

00000

00000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00668 CERTIFICATE OF DEATH 00663									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR P. M.	
Rose Anna Frackman DEAVER						January 25, 1969		6:25 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
female		white		8-1-79		89 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		U.S.A.				Carroll			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Sykesville		Springfield State Hospital		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland				Balto. 15				3124 Virginia Avenue	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
John Frackman			Mary Sader						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
no		213-10-0873		Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years Years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>CBS associated with senile brain disease with psychotic reaction.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>10-29-68</u> , 19 <u> </u> , to <u>1-25-69</u> , 19 <u> </u> , that (I) (we) lost saw the deceased alive on <u>1-25-69</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Francisco J. Ceballos, M.D.</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED <u>1-25-69</u>				
22d. PHYSICIAN'S NAME (Type) Francisco J. Ceballos, M.D.					22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		29 JAN 69		New Cathedral Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR <u>J. E. Lowell Lemmon</u> ADDRESS J. E. Lowell Lemmon 4611 Park Heights Ave.					25a. REC'D BY REGISTRAR DATE JAN 30 1969		25b. REGISTRAR'S SIGNATURE <u>J. E. Lowell Lemmon</u>		



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00669

00664

1. DECEASED-NAME (Type or print) MILTON EDGAR DEVILBISS			2a. DATE OF DEATH Month Jan Day 17 Year 1969			2b. HOUR 7:30 A.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH SEPT. 29 - 1894		6. AGE (In years last birthday) 74 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md.	
10. CITY OR TOWN OF DEATH WESTMINSTER			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARRILL COHEN HOSP			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FARMER - OWNER - RETIRED	
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE MARYLAND			13b. COUNTY NEW WINDSOR			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last HOWARD H. DEVILBISS ALICE			15. MOTHER'S MAIDEN NAME First Middle Last NUSSBAUM				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO			16b. SOCIAL SECURITY NO. 217-364575			17. INFORMANT LEAH H. DEVILBISS, NEW WINDSOR MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery heart disease 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of neck, left femur DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/5/69.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral ischemia							
19a. DATE OF OPERATION 1/8/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fractured left hip		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1/5 , 19 69 , to 1/17 , 19 69 , that (I) (we) last saw the deceased alive on 1/16/69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard P. Darymple M.D.				22c. DATE SIGNED 1/17/69.		22d. PHYSICIAN'S NAME (Type) RICHARD P. DARYMPLE	
22e. ADDRESS WESTMINSTER, MD.				23a. NAME OF CEMETERY OR CREMATORY BRICK HURCH CEM.		23b. LOCATION (City or Town) (County) (State) WAKEFIELD, MD	
23c. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23d. DATE 1-19-1969		24. FUNERAL DIRECTOR DR. H. H. H. NEW WINDSOR MD		25a. REC'D BY REGISTRAR JAN 20 1969	
25b. REGISTRAR'S SIGNATURE Charles Judge							

13000

13000

JAN 24 1989

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00670										MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00665									
1. DECEASED-NAME (Type or print) Maurice Ross Fair										2a. DATE OF DEATH Month January Day 1 Year 1969										2b. HOUR 8:30 MIN A.M.									
3. SEX Male					4. RACE White					5. DATE OF BIRTH December 1, 1876					6. AGE (In years last birthday) 92 YRS.					IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Maryland					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Carroll Md.														
10. CITY OR TOWN OF DEATH Taneytown					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 69 George Street					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Linotype Operator					12b. KIND OF BUSINESS OR INDUSTRY Printing														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland					13b. COUNTY Carroll					13c. CITY OR TOWN Taneytown					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 69 George Street									
14. FATHER'S NAME First Daniel Middle Fair Last Mary					15. MOTHER'S MAIDEN NAME First Mary Middle Reindollar Last Reindollar																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. 212-03-0506					17. INFORMANT Mrs. M. Ross Fair, Taneytown, Maryland Address																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Acute Coronary Occlusion few min DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis 20 yrs DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis 20 yrs										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 12/7 , 19 64 to 1/1 , 19 69 , that (I) (we) last saw the deceased alive on 11/29 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.																													
22b. SIGNATURE R.S. McVaugh, M.D.					22c. DATE SIGNED 2 Jan 69					22d. PHYSICIAN'S NAME (Type) R.S. McVaugh, M.D.										22e. ADDRESS Taneytown, Maryland 21787									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE 1/4/69					23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery					23d. LOCATION (City or Town) (County) (State) Taneytown, Carroll, Maryland														
24. FUNERAL DIRECTOR C.O. Fuss & Son					25a. REC'D BY REGISTRAR JAN 3 1969					25b. REGISTRAR'S SIGNATURE Charles Judge																			

[Faint handwritten notes at the bottom of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00671				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00666			
Item#5, Film#409 1/30/69 km				CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Catherine			V.		Fitzpatrick	Month 1 Day 18 Year 69			6:50a		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		1-17-1895		74		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Carroll Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			Springfield State Hospital			Beauty parlor operator					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Washington			Hagerstown				Hagerstown, Md.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
William					Fitzpatrick	Margaret					Jordon
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No			215-56-3473T			Records			Springfield State Hospital Sykesville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										days	
IMMEDIATE CAUSE (a) Cardiac insufficiency											
4124 DUE TO, OR AS A CONSEQUENCE OF										years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) ASCVD											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1-13-1936, to 1-18-1969, that (I) (we) last saw the deceased alive on 1-18-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Arnold Melman, M.D.						M.D.				1/18/69	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Arnold Melman, M.D.						Springfield State Hospital Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			1-26-69		Freudon Cemetery			Sykesville, Md.			
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Harry W. Haight						Sykesville, Md.		JAN 28 1969		Charles J. J...	

1

100

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00672

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00667

1. DECEASED-NAME (Type or Print) JOHN EDWARD FREYMAN			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year 1-29 1969			2b. HOUR ? M M		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH NOV. 13, 1890	6. AGE (In years last birthday) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN. 	2c. DATE PRONOUNCED DEAD Month 2 Day 1 Year 1969		
7a. BIRTHPLACE (State or foreign country) CARROLL CO.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL CO.		
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RD 5 DENNINGS ROAD		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY -		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RD 5 DENNINGS ROAD
14. FATHER'S NAME First WILLIAM Middle EDWARD Last FREYMAN			15. MOTHER'S MAIDEN NAME First MARY Middle R. Last NINER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. 216-03-5862			17. INFORMANT WILLIAM D. FREYMAN		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123 (b) DUE TO, OR AS A CONSEQUENCE OF (c) 			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE W. L. Peaches			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 2-6-69		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS 135 E. Main St. Westminster, Md.		
23a. BURIAL (Cremation, Removal) (Specify) BURIAL		23b. DATE 2/4/69		23c. NAME OF CEMETERY OR CREMATORY DEER PARK CEMETERY		23d. LOCATION (City or Town) (County) SMALLWOOD, CARROLL CO., MD.		
24. FUNERAL DIRECTOR J. S. Myers, Jr., Westminster, Md.				25a. SPEC'D. BY REGISTRAR DATE FEB 4 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

**FOR STATE
HEALTH DEPT.**

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00673

00668

1. DECEASED-NAME (Type or Print)				First Middle Last				2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year				2b. HOUR 3:18 p.m.	
RUFUS				OSWALD				GASKINS				1/6/ 1969	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year				2d. HOUR 3:18 p.m.	
male	negro	MAY 7 1888	80 YRS.					January 6, 1969					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md.	
VIRGINIA		USA				Carroll							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY							
Sykesville		Springfield State Hospital		PORTER		MUSICAL SALES							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland						Baltimore				1022 N. Carey St.			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last									
JAMES HENRY GASKINS				LOVELY ROBINSON									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
				218-10-2146		SARAH SMITH 1105 ASHBURTON							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inactive Mitral Valvulitis (Rheumatic)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary Emphysema</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)				22b. DATE SIGNED 1/7/69					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
BURIAL		1/10/69		WESTERN STAR CEM.		CATONVILLE MD							
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
DONALD E. GLOVER 170 N. PATTERSON ST.				DATE JAN 16 1969				Charles Judge					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Virginia

USA

PORTER

JAMES HENRY GASKINS

LOVELY ROBINSON

218-10-2116 SARAH & WILLIAM 1102 ASKPORTON

00674

CERTIFICATE OF DEATH

00669

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 1/2 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bernard Clark Gibson Sr.		4. DATE OF DEATH 1 - 4 19 69	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-9-91
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY retired	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert F. Gibson		14. MOTHER'S MAIDEN NAME Maude Thompson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 212-03-17149	
17. INFORMANT Records Springfield Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO 7070 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bedsore DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome due to Atherosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-27 , 19 68 , to 1-4 , 1969, that (I) (we) last saw the deceased alive on 1-4 19 69 , and that death occurred at 6:30 AM , from causes and on the date stated above.			
22a. SIGNATURE M. R. Etchison		22b. DATE SIGNED 1/4/69	
22c. PHYSICIAN'S NAME (Type) Mario E. Comas M.D.		22d. ADDRESS Springfield State Hospital-Sykesville	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 7, 1969	
23c. NAME OF CEMETERY OR CREMATORY Frederick Memorial Park		23d. LOCATION (City or Town) (County) (State) Frederick Frederick Md.	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md.		25a. REC'D BY REGISTRAR Jan 8 1969	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8330

UNITED STATES OF AMERICA

8330

Secretary

Chief Clerk

Director

Assistant Secretary

Chief Clerk

Director

1 - 1

1 - 1

1 - 1

1 - 1

W

1 - 1

W

W

1 - 1

1 - 1

1 - 1

1 - 1

1 - 1

1 - 1

1 - 1

1 - 1

1 - 1

1 - 1

1 - 1

1 - 1

1 - 1

1 - 1

1 - 1

1 - 1

1 - 1

1 - 1

1 - 1

1 - 1

1 - 1

1 - 1

1 - 1

1 - 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 115 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
FRANKLIN		Pool	Green		JAN. 22, 1969		3 P M		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE	White		Nov. 17, 1903		65 YRS.		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md.	U. S. A.				CARROLL				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Sykesville		Arthur Ave		Mechanic		Auto.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.		CARROLL		Sykesville				Arthur Ave.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
George W.		Green			Ida -				Kidwell
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		216 100317		MRS. Mae Hush		Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 CORONARY INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD. DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HR. 10 YRS 10 YRS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from July 19 64, to 1-22, 19 69, that (I) (we) last saw the deceased alive on 1-22 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. ADDRESS		22e. REGISTRAR'S SIGNATURE			
R. V. Houck		1-24-69		Sykesville, Md.		M.D. DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE		22g. DATE			
R. V. Houck		Sykesville, Md.		Harry W. Haight		JAN 28 1969			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		1-25-69		New Oakland		Sykesville			Md.
24. FUNERAL DIRECTOR		24a. ADDRESS		24b. DATE		24c. REGISTRAR'S SIGNATURE		24d. DATE	
Harry W. Haight		Sykesville, Md.		JAN 28 1969		Mae Hush		JAN 28 1969	

00800

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

NATIONAL CENTER FOR HUMAN GROWTH

000

100

100

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00676 CERTIFICATE OF DEATH 00671									
1. DECEASED-NAME (Type or print)			First GEORGE	Middle WASHINGTON	Last GREEN	2a. DATE OF DEATH Month 1 Day 31 Year 69			2b. HOUR A 6:30 M
3. SEX Male		4. RACE White		5. DATE OF BIRTH 08/04/1886		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll County Md.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address). Springfield State Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Wood pattern maker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY --		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4412 Old York Road	
14. FATHER'S NAME First Middle Last George W Green			15. MOTHER'S MAIDEN NAME First Middle Last Mary Frances Lynch						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. 218-03-7725-A		17. INFORMANT Address Springfield Hosp. Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ✓
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>CBS assoc. with cerebral arteriosclerosis with behavioral reaction</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/06</u> , 19 <u>67</u> , to <u>01/31</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>01/31</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Milton Buschman</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/31/69		
22d. PHYSICIAN'S NAME (Type) Milton Buschman, M.D.		22e. ADDRESS Springfield State Hospital							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/3/1969		23c. NAME OF CEMETERY OR CREMATORY Silver Brook Cemetery		23d. LOCATION (City or Town) (County) (State) Wilmington, Delaware			
24. FUNERAL DIRECTOR Eugenia K. Seitz 5209 York Road Seitz Funeral Home Baltimore, Md. 21212				25a. REC'D BY REGISTRAR FEB 3 1969		25b. REGISTRAR'S SIGNATURE			

17500

UNITED STATES OF AMERICA

17500

17500

17500

17500

17500

17500

17500

17500

17500

17500

17500

17500

17500

17500

17500

17500

17500

17500

17500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00677					00672				
1. DECEASED-NAME (Type or print) ELNER (MRS) HALL GRESHAM					2a. DATE OF DEATH Month JANUARY Day 12 Year 1969			2b. HOUR 9:30 M	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 4-02-00		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Unk.			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2201 Ettings St.	
14. FATHER'S NAME First William Middle Hall Last Hall			15. MOTHER'S MAIDEN NAME First Martha Middle Hall Last Hall						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 219-16-3664		17. INFORMANT GLADYS GILSTRAP Address 2108 BEYANT AVE. Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Peripheral arterial insufficiency with gangrene of both lower legs APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4124 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis Years									
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiovascular disease Years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 12-31-68 , 19__, to 1-12-69 , 19__, that (I) (we) last saw the deceased alive on 1-12-69 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Paul G. Ensor, M.D. DEGREE M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED 1-12-69				
22d. PHYSICIAN'S NAME (Type) Paul G. Ensor, M.D.					22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-17-69		23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN CEM.		23d. LOCATION (City or Town) (County) (State) BALTO.			
24. FUNERAL DIRECTOR Geo. H. Nelson ADDRESS F.H. 1348 Calhoun St.					25a. REC'D BY REGISTRAR JAN 17 1969 DATE		25b. REGISTRAR'S SIGNATURE [Signature]		

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00678 CERTIFICATE OF DEATH 00673											
1. DECEASED-NAME (Type or print) XXXXXXXXXX First <u>Robert</u> Middle <u>Lee</u> Last <u>Griffis</u>			2a. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>69</u>			2b. HOUR <u>7:45</u> PM					
3. SEX <u>MALE</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>3-15-02</u>		6. AGE (In years last birthday) <u>66</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Carroll</u> Md.					
10. CITY OR TOWN OF DEATH <u>SYKESVILLE</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Springfield State</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Printer</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>self-employed</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>SILVER SPRING</u>			13b. COUNTY <u>MONT</u>		13c. CITY OR TOWN <u>MD</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>10305 Douglas Ave</u>		
14. FATHER'S NAME First <u>Richard</u> Middle <u>--</u> Last <u>Griffis</u>			15. MOTHER'S MAIDEN NAME First <u>Elizabeth</u> Middle <u>--</u> Last <u>Pearson</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <u>212-14-583A</u>		17. INFORMANT <u>Mary A. Griffis</u> Address <u>Sil. Spr. Md.</u> XXXXXXXXXX <u>10305 Douglas Avenue</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <u>4379</u> IMMEDIATE CAUSE (a) <u>Chronic Brain Syndrome associated</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Arteriosclerosis - Psychotic Reaction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Star</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Tar Enson's Disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>8/2</u> , 19 <u>68</u> , to <u>1/5</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/5</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Paul G. Ensor, M.D.</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>1-5-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Paul G. Ensor, M.D.</u>						22e. ADDRESS <u>Springfield State Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-9-1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges, Maryland</u>					
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>						ADDRESS <u>8434 Georgia Avenue</u>		25a. REC'D BY REGISTRAR <u>JAN 10 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>	

17-1-0

54

3.9/10

42 17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00679		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00674	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last ANNA MARIE HAMMETT			2a. DATE OF DEATH Jan Month 18 Day 1969 Year			2b. HOUR 10 ²⁵ M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH DEC 16 1891		6. AGE (In years lost birthday) 77 YRS.	
7a. BIRTHPLACE (State or foreign country) BALTO. MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL CO. Md.	
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL CO. GEN. HOSP. HOUSE-WIFE ALSO IN SHOE FACTORY		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY OPERATOR	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER RD #4		14. FATHER'S NAME First Middle Last JAMES PETR		15. MOTHER'S MAIDEN NAME First Middle Last MARY ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 213-16-0272A		17. INFORMANT MRS. MARGARET BLOOM		Address WESTMINSTER RD #4	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4339 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Thrombosis 2 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Coronary Thrombosis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 13, 1969, to Jan 18, 1969, that (I) (we) last saw the deceased alive on Jan 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John S. Harshey, M.D.				DEGREE M.D.		22c. DATE SIGNED 1/18/69	
22d. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.				22e. ADDRESS 8 Anchor St. Westminster Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1/21/69		23c. NAME OF CEMETERY OR CREMATORY KRIDERS, CEMETERY		23d. LOCATION (City or Town) (County) (State) WESTMINSTER RD MD	
24. FUNERAL DIRECTOR J.S. Myers, Jr., Westminster, Md				ADDRESS 250. REC'D BY REGISTRAR DATE JAN 21 1969		25b. REGISTRAR'S SIGNATURE	

00000

00000

00000

00000

CERTIFICATE OF DEATH

00680

00675

1. DECEASED-NAME (Type or print) <i>Ruth</i> First <i>C.</i> Middle <i>Hammett</i> Last			2a. DATE OF DEATH Month <i>January</i> Day <i>10</i> Year <i>1969</i>			2b. HOUR <i>12:30 AM</i>	
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>Sept 25/92</i>		6. AGE (In years last birthday) <i>76</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Balto.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll Co.</i> Md.	
10. CITY OR TOWN OF DEATH <i>Linksburg</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hamben Road</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Linksburg</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First <i>Adolph</i> Middle <i>Pick</i> Last <i>Ritter</i>		15. MOTHER'S MAIDEN NAME First <i>Ida</i> Middle <i>Ritter</i> Last <i>Ritter</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>4310</i>	
17. INFORMANT <i>Sothern C. Hammett</i> Address <i>Route 3 Washington</i>		17. INFORMANT <i>Sothern C. Hammett</i> Address <i>Route 3 Washington</i>		17. INFORMANT <i>Sothern C. Hammett</i> Address <i>Route 3 Washington</i>		17. INFORMANT <i>Sothern C. Hammett</i> Address <i>Route 3 Washington</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident - hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>40 hours</i> <i>9 years</i> <i>9 years</i>						PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1-8</i> , 19 <i>69</i> , to <i>1-10</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1-9</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>E. M. Williams M.D.</i>		22c. DATE SIGNED <i>1-10-69</i>		22d. PHYSICIAN'S NAME (Type) <i>E. M. Williams</i>		22e. ADDRESS <i>1964 Keisterstown Rd Keisterstown Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1-13-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olive Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Handabottom, Balto., Md.</i>	
24. FUNERAL DIRECTOR <i>Spring Byers</i>		24b. ADDRESS <i>8728 Liberty Rd</i>		25a. REC'D BY REGISTRAR <i>JAN 15 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100000

100000

100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last CARL EGGART HOMBERG			2a. DATE OF DEATH Month Day Year 01 23 69			2b. HOUR A 8:30 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 05/24/94		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Michigan		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5659 Purdue Avenue	
14. FATHER'S NAME First Middle Last CHARLES HOMBERG			15. MOTHER'S MAIDEN NAME First Middle Last ELIZABETH McKINSEY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes		(If yes give war or dates of service) WW I		16b. SOCIAL SECURITY NO. 367-16-9757		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral lobarpneumonia 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the lung DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days	
								months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome associated with cerebral arteriosclerosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 07/22/1968, to 01/23/1969, that (I) (we) lost saw the deceased alive on 01/23/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Suha Ozgun, M.D.				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/23/69			
22d. PHYSICIAN'S NAME (Type) Suha Ozgun				22e. ADDRESS Springfield State Hosp., Sykesv., Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 1/24/69		23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory		23d. LOCATION (City or Town) (County) (State) Balto City		23e. REGISTRATION JAN 27 1969	
24. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home-6500 York Rd-21212									

100-443886-1150

STIR

00682

00677

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) LILLIE I. HOOPER			2a. DATE OF DEATH Month 1 Day 22 Year 49			2b. HOUR 12:30 P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH July 3, 1891		6. AGE (In years last birthday) 77 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll, Md.	
10. CITY OR TOWN OF DEATH Mt. Airy		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R. D. 2		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER R. D. 2		14. FATHER'S NAME First Middle Last Eugene Pickett		15. MOTHER'S MAIDEN NAME First Middle Last Verdie Harn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. None		17. INFORMANT Mr. William T. Hooper Same As #13		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic CVD 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1965 , 19____, to 11/22/49 , 19____, that (I) (we) lost the deceased on 11/22/49 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. E. Robertson MD DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/22/49	
22d. PHYSICIAN'S NAME (Type) Dr. M. E. Robertson				22e. ADDRESS New Windsor, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/25/1969		23c. NAME OF CEMETERY OR CREMATORY Taylorsville		23d. LOCATION (City or Town) (County) (State) Taylorsville, Carroll, Md.	
24. FUNERAL DIRECTOR C. M. Waltz, Box 241, Sykesville, Md.				25a. REC'D BY REGISTRAR JAN 27 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

15300

RECEIVED

15300

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00683

00678

1. DECEASED-NAME (Type or print) First Middle Last Frederick F Husselbaugh			2a. DATE OF DEATH Month Day Year JAN 6 1969		2b. HOUR 8:00 A M			
3. SEX Male	4. RACE White		5. DATE OF BIRTH JAN. 18, 1898		6. AGE (In years lost birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.		
10. CITY OR TOWN OF DEATH MARRIOTTSTVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ARRINGTON Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Stone Mason		12b. KIND OF BUSINESS OR INDUSTRY Building		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY CARROLL		13c. CITY OR TOWN MARRIOTTSTVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Arrington Rd.
14. FATHER'S NAME First Middle Last Frederick - Husselbaugh			15. MOTHER'S MAIDEN NAME First Middle Last MARY - Stricker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 213 01 8620		17. INFORMANT Address MRS. Lola Husselbaugh Marriotttsville Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASCVD. DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSIVE CARDIO VASCULAR DIS. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES 10 YRS. 20 YRS.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 12-23, 1968, to 1-6, 1969, that (I) (we) last saw the deceased alive on 1-6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE A. H. H. M.D. DEGREE		22c. DATE SIGNED 1-7-69		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (Type) R. V. Hark, JR		22e. ADDRESS Sykesville, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-9-69		23c. NAME OF CEMETERY OR CREMATORY Westey Freedom		23d. LOCATION (City or Town) (County) (State) Sykesville, Md.		
24. FUNERAL DIRECTOR Harry W. Haight		ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR DATE: 10 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00682

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00679

1. DECEASED-NAME (Type or Print) <u>Sophia</u> <u>LaVene</u>			Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 1/18 19 69			2b. HOUR 3:00 A.M.				
3. SEX female		4. RACE negro		5. DATE OF BIRTH Oct. 30, 1968		6. AGE (In years last birthday) YRS. 2 MONTHS 18 DAYS		7c. DATE PRONOUNCED DEAD Month Day Year January 18, 19 69		2d. HOUR 1:00 P.M.			
7a. BIRTHPLACE (State or foreign country) <u>Maryl and</u>			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll Md.				
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RD 3			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>			13b. COUNTY Carroll			13c. CITY OR TOWN Sykesville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER RD 3	
14. FATHER'S NAME First Middle Last Unknown			15. MOTHER'S MAIDEN NAME First Middle Last Christine Jason			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. None			17. INFORMANT ADDRESS Christine Jason Same As #13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>484X</u> <u>Interstitial Pneumonitis (DSII)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Werner U. Spitz</u>			EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED 1/19/69				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 1/20/1969			23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery			23d. LOCATION (City or Town) (County) (State) Carroll Co., Md.				
24. FUNERAL DIRECTOR ADDRESS C. M. Waltz, Box 241, Sykesville, Md.						25a. REC'D BY REGISTRAR DATE JAN 21 1969			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

07000

THE EXAMINER'S CERTIFICATE OF DEATH

1900

THE STATE OF NEW YORK

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		Jan 15, 1900		New York City	
Cause of Death		Disease		Symptoms		Time of Death		Signature of Examiner	
Heart Disease		Myocarditis		Chest Pain		10:00 AM		J. Smith	
Medical History		Family History		Social History		Occupation		Signature of Physician	
None		None		None		None		None	
Burial Place		Burial Date		Burial Time		Burial Place		Signature of Undertaker	
Cemetery		Jan 16, 1900		11:00 AM		Cemetery		None	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in items 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

after death.

MEDICAL CERTIFICATION

1

00685

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00680

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED		Month		Day		Year		2b. HOUR			
EMANUEL						JEFFERSON				1-4-		19		69		4:00			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS		HOURS		MIN		2c. DATE PRONOUNCED DEAD Month			
male		Negro		11-06-27		41 YRS.										1 Day 4 Year 1969			
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH				2d. HOUR			
Maryland				U.S.A.								Carroll				4:00			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY							
Sykesville				Springfield State Hospital				Postal employee											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. CITY OR TOWN				13c. INSIDE CITY LIMITS?				13e. STREET AND NUMBER							
Maryland				Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				1123 Druid Hill Ave.,							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
First Middle Last				First Middle Last															
Malichi Jefferson				Inez Hare - dec.															
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				18b. SOCIAL SECURITY NO.				18c. CITY OR TOWN				18d. INSIDE CITY LIMITS?				18e. STREET AND NUMBER			
Yes				1-29-44-4-5-46				217-22-3710				Springfield State Hospital Records							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Bronchopneumonia, right lung.</u> DUE TO, OR AS A CONSEQUENCE OF 485X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <u>Status epilepticus.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days hours																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?											
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE				W. Glenn Speicher, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED							
EXAMINER'S NAME (Type)				W. Glenn Speicher, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				1-5-69							
23a. BURIAL, CREMATION REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)							
Burial				Jan. 8 1969				Baltimore National				Baltimore Md. Carroll							
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
Joseph L. Hines				DATE JAN 14 1969				Charles Judge											

00000

THE STATE OF TEXAS, COUNTY OF DALLAS, BEFORE ME, the undersigned authority, on this day personally appeared _____, known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

My commission expires _____.

NOTARY PUBLIC
STATE OF TEXAS

(T)

00000

00000

000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00686

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00681

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR P		
BEATRICE HENNERITA KANE						JANUARY 16, 1969			3:05		
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female	White		9-15-01			67 YRS.		MONTHS	DAYS	HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Pennsylvania		U.S.A.				Carroll Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			Springfield State Hospital			Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Allegheny			Cumberland		YES		447 Williams St.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
John					Harman	Eva					Runk
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
No			214-07-2580A			Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute peritonitis and mesenteric thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Right iliac artery thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Day Days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>7-26-67</u> , 19__, to <u>1-16-69</u> , 19__, that (I) (we) last saw the deceased alive on <u>1-16-69</u> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Agustin del Campo MD</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-17-69			
22d. PHYSICIAN'S NAME (Type) Agustin del Campo, M. D.						22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		1/20/69		St Mark's Episcopal Cemetery		Lewistown		Penna			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Silcox-Merritt Funeral Service Cumberland, Md						JAN 21 1969		<u>Charles Judge</u>			

2361

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR-1 (4)
30M REV. 1/68

00687

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00682

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) HENRY VERNON KELLER, JR.			2a. DATE OF DEATH Month 1 Day 21 Year 69			2b. HOUR 12:15 P
3. SEX Male	4. RACE White		5. DATE OF BIRTH 01/09/10		6. AGE (In years last birthday) 59 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Painter		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Balto.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER West "K" Street, 21219	
14. FATHER'S NAME First Henry Middle Vernon Last Keller, Sr.			15. MOTHER'S MAIDEN NAME First Sarah Middle Runk Last Runk			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214-05-4128		17. INFORMANT Address Hospital records		
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pyelonephritis DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days mths years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CBS associated with arteriosclerosis with psychotic reaction						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from Jan. 06, 19 69 , to 01/21, 19 69 , that (I) (we) lost saw the deceased alive on 01/21, 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Suha Ozgun				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 01/21/69	
22d. PHYSICIAN'S NAME (Type) Suha Ozgun, M.D.				22e. ADDRESS Springfield State Hospital, Sykes., Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-23-69	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City or Town) (County) (State) Pikesville Balto., Md.	
24. FUNERAL DIRECTOR Mr. J. Tucker & Son, Balto., Md.				25a. REC'D BY REGISTRAR DATE 28 1969		25b. REGISTRAR'S SIGNATURE James J. J...

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00688

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00683

1. DECEASED-NAME (Type or print) <u>Arlene</u>		First <u>MAY</u> Middle <u>Kopp</u> Last		2a. DATE OF DEATH Month <u>JAN</u> Day <u>13</u> Year <u>1969</u>		2b. HOUR <u>11:50</u> M	
3. SEX <u>female</u>		4. RACE <u>white</u>		5. DATE OF BIRTH <u>11-14-26</u>		6. AGE (in years lost birthday) <u>42</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>York Co., Pa.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Carroll</u>	
10. CITY OR TOWN OF DEATH <u>Lineboro</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>8 Church St</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Nurse</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased admission) STATE <u>Maryland</u>		13b. CITY OR TOWN <u>Carroll</u>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>8 Church St</u>	
14. FATHER'S NAME First <u>Arthur</u> Middle <u>C</u> Last <u>albright</u>		15. MOTHER'S MAIDEN NAME First <u>Elise</u> Middle <u>Landis</u> Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16b. SOCIAL SECURITY NO. <u>179-20-6513</u>		17. INFORMANT <u>Lenore Kopp</u> Address <u>Lineboro Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno Carcinoma Colon</u> <u>1538</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>with metastases to liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>13 months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital), attended the deceased from <u>3/30</u> , 19 <u>51</u> , to <u>1/13</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Jan 12</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>W.H. Foard</u> M.D. DEGREE		22c. DATE SIGNED <u>1-13-69</u>		22d. PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u>			
22e. ADDRESS <u>234 Main St</u> <u>Manchester, Md 21102</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan 16 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Lutheran</u>		23d. LOCATION (City or Town) (County) (State) <u>Lineboro Carroll Md</u>	
24. FUNERAL DIRECTOR <u>Al Seiffert & Son</u>		ADDRESS <u>Old Rock, Pa.</u>		25a. REGISTRATION <u>JAN 15 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

000000

000000

000000

JAN 1 1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00689		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		00684	
Item#11 FilmG408 1/20/69 km					
1. DECEASED-NAME (Type or print)			2a. DATE OF DEATH		2b. HOUR
First Middle Last KATHERINE LOUISE KUHN			Month Day Year JAN 13 1969		9:25 AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Female	White	18 Sept 1904		64 YRS.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
CARROLL Co.	U.S.		CARROLL Md.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
WESTMINSTER	62 Court Street		HOUSEWIFE - CLERK		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
MD	CARROLL	WESTMINSTER		62 COURT STREET	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
First Middle Last Vincint Yingling	First Middle Last JERAM ZENDGRAFF				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT			
	220-18-0518	ANDREW KUHN SR. - ZENDEGRAFF			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1938
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from April 1957 to present 1969, that (I) (we) last saw the deceased alive on 25 Nov 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dean H. Griffin				22c. DATE SIGNED 13 JAN 69	
22d. PHYSICIAN'S NAME (Type) DEAN H. GRIFFIN				22e. ADDRESS 19 Ridge Rd. WESTMINSTER MD	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/16/69		23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery Westminster Md. Carroll Co.	
24. FUNERAL DIRECTOR J.S. Myers, Jr., Westminster, Md.		ADDRESS		25a. RECEIVED BY REGISTRAR JAN 15 1969 DATE	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

1880

THE NEW YORK PUBLIC LIBRARY ASTOR LENOX TILDEN FOUNDATION

1880

RECEIVED

ANDREW J. KUNY JR

250-11-108

1880

1880

RECEIVED

1880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00690

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00685

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last JESSIE LOUISE LEHNAFF			2a. DATE OF DEATH Month Day Year Jan. 12 1969			2b. HOUR SP M					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH APRIL 28, 1881		6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) ENGLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL CO.					
10. CITY OR TOWN OF DEATH WESTMINSTER			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.F.D.#5			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSE-WIFE - FAMILY COMPANION			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.F.D.#5		
14. FATHER'S NAME First Middle Last GEORGE CROXTON			15. MOTHER'S MAIDEN NAME First Middle Last L. GRACE E. HUSK								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. 120-18-2874-A		17. INFORMANT MRS PAMELA RIDGEWAY			Address SAME ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pneumonia 486X DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Generalized atherosclerosis, Pyelitis											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from JAN 8, 1969, to Jan. 12, 1969, that (I) (we) last saw the deceased alive on Jan 11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. A. Caricofe M.D.						DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/12/69	
22d. PHYSICIAN'S NAME (Type) J. A. CARICOFE M.D.						22e. ADDRESS UNION BRIDGE, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 1/14/69		23c. NAME OF CEMETERY OR CREMATORY MEADOW BRANCH CEM. WESTMINSTER, MD.			23d. LOCATION (City or Town) (County) (State) WESTMINSTER, MD.			
24. FUNERAL DIRECTOR J. S. Myers, Jr. Westminster, Md.						25a. REC'D BY REGISTRAR DATE JAN 15 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

TO THE HONORABLE SECRETARY OF THE
NAVY
WASHINGTON, D. C.
FROM THE
NAVY DEPARTMENT
WASHINGTON, D. C.
JANUARY 1, 1900
SIR:
I have the honor to acknowledge the receipt of your letter of the 29th inst. in relation to the matter mentioned therein.
The same has been referred to the proper authorities for their consideration.
Very respectfully,
J. D. LONG
NAVY DEPARTMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00691										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00686									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Middle Last CLARIS Ritha Ludwig										Month Day Year JAN 27 1969										8P M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years lost birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS														
FEMALE			White			Aug. 20, 1939			29 YRS.			MONTHS DAYS HOURS MIN																	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Md.			U.S.A.						CARROLL																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
Sykesville			OAKLAND Road			Nurses Aide			Hospital																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER																	
Md.			CARROLL			Sykesville						OAKLAND Road																	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																										
First Middle Last LAWRENCE ELTON Ludwig			First Middle Last Christina J. Ludwig																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address																				
No						MR. LAWRENCE Ludwig - Sykesville, Md.																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) Generalized Carcinomatosis										1 1/2 yrs.																			
180X DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Cervix										2 yrs.																			
DUE TO, OR AS A CONSEQUENCE OF (c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. none					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 4-4-59, 19 to 1-27-69, that (I) (we) last saw the deceased alive on 1-27 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										22c. DATE SIGNED																			
D.D. CAPLES										1-29-69																			
22d. PHYSICIAN'S NAME (Type) D.D. CAPLES, M.D.										22e. ADDRESS 6 Hanover Rd. Reisterstown, Md. 21136																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
BURIAL					1-30-69					LAKE View Cemetery					Sykesville Carroll Md														
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
Harry W. Haight Sykesville, Md.										DATE JAN 31 1969										J. Charles Judge									

00000

STATE OF NEW YORK

1900

11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
30M REV. 7-68

00692										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00687									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
FRANCIS STEWART MILES										JANUARY 10 1969										M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
MALE			White			5-28-1898			70 YRS.			MONTHS			DAYS			HOURS											
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Maryland			U. S. A.						CARROLL Co.																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
Westminster			Bird View Rd			Book Keeper																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER																	
Md			CARROLL			Westminster						Bird View Rd																	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
First Middle Last					First Middle Last																								
Samuel F. Miles					Virginia Waples																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																			
No					312-07-7733					MARY BELK MILES - Same																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>Coronary heart failure</u>																													
DUE TO, OR AS A CONSEQUENCE OF (b) _____																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																													
DUE TO, OR AS A CONSEQUENCE OF (c) _____																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
<u>Coronary Prostate</u>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>Goldman</u>										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED														
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					1-13-69					Woodlawn Cemetery					Woodlawn Md														
24. FUNERAL DIRECTOR										ADDRESS					25a. REC'D BY REGISTRAR DATE					25b. REGISTRAR'S SIGNATURE									
Armstrong Funeral Chapel - 4600 Lib. Hts															13 1969					James Judge									

MEDICAL CERTIFICATION

10000

10000

10000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH					2b. HOUR		
First Middle Last CHARLES DOLL MITCHELL					Month Day Year 1 23 69					7:00 M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		02/16/1894			74 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Maryland		U.S.A.					CARROLL					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
SYKESVILLE			SPRINGFIELD STATE HOSP.			Maintenance man						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			BALTO.		Balto.				2714 Westfield Avenue			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last JOHN ? MITCHELL			First Middle Last Cora ? Doll									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT							
yes			1917-1919		213-05-3682-A							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>right lung abscess</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic heart disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days wks yrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CBS assoc. with cerebral arteriosclerosis without qualifying phrase												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>07/18</u> , 19 <u>68</u> , to <u>01/23</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>01/23</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Suha Ozgun, M.D.					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/23/69					
22d. PHYSICIAN'S NAME (Type) Suha Ozgun					22e. ADDRESS Springfield State Hospital, Sykesv., Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial		1/27/69.		Loudon Park Cemetery			Baltimore, Md.					
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leonard J. Ruck, Inc. Balto. Md. 21214							DATE JAN 24 1969		Charles Judge			

00694

CERTIFICATE OF DEATH

00689

1. DECEASED-NAME (Type or print) First Middle Last CLAUDE WARREN MITTEN			2a. DATE OF DEATH Month Day Year 1 16 69			2b. HOUR 11:59 M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH SEPT. 21, 1889		6. AGE (In years last birthday) YRS. MONTHS DAYS 79	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL COUNTY Md.	
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL CO. GEN. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PAPERHANGER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last WILLIAM W. MITTEN		15. MOTHER'S MAIDEN NAME First Middle Last LAURA SLONAKER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES (If yes give war or dates of service) MEXICAN			
16b. SOCIAL SECURITY NO. 217 05 5326		17. INFORMANT MRS DALE E. WEAVER		16c. ADDRESS 164 LIBERTY ST. WESTMINSTER, MD.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac-arrest - Ventricular Fibrillation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4124 (b) ACVD Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) ACVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 24 hr.
--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from June, 1967 , to 1/16, 1969 , that (I) (we) lost saw the deceased alive on 1/16, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Philip A. Mercer DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED Jan. 16, 1969			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 20, 1969		23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		23d. LOCATION (City or Town) (County) (State) Westminster, Carroll Md.	
24. FUNERAL DIRECTOR Thomas D. Fletcher Funeral Home Westminster, Md.		25a. RECEIVED BY REGISTRAR JAN 22 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00000

RECEIVED

00000

1

00000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00695										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00690									
1. DECEASED-NAME										2a. DATE OF DEATH										2b. HOUR									
(Type or print)										Month										Day									
Charles Aloysius Mark										Jan										25									
3. SEX										4. RACE										5. DATE OF BIRTH									
Male										White										May 2-1881									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
Maryland										USA										9. COUNTY OF DEATH									
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)									
Manchester										Home Long View Nursing Home 1284 Main St										Fireman									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN									
Md										Carroll										Manchester									
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown									
John										Mary										No									
16b. SOCIAL SECURITY NO.										17. INFORMANT										17. ADDRESS									
220-30-273										Mrs John Pierce										Manchester, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a)										Breache pneumonia										6 days									
185X										DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Adenocarcinoma prostate with metastases										3 yrs									
DUE TO, OR AS A CONSEQUENCE OF										(c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?									
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
										HOUR A.M. Month Day Year																			
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION									
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work																				Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from June, 1957, to Jan 25, 1969, that (I) (we) last saw the deceased alive on Jan 24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										22c. DATE SIGNED																			
W.H. Ford M.D.										1-25-69																			
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
W.H. Ford MD										Manchester, Md 21102																			
23a. BURIAL, CREMATION, or other disposition										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY									
Burial										Jan. 28, 1969										Druid Ridge Cem.									
23d. LOCATION (City or Town) (County) (State)										23e. LOCATION (City or Town) (County) (State)																			
Pikesville, Md.																													
24. FUNERAL DIRECTOR										24b. ADDRESS										25a. RECEIVED BY REGISTRAR									
Tipton - Eline Funeral Home										Hampstead, Md.										JAN 28 1969									
25b. REGISTRAR'S SIGNATURE										25c. REGISTRAR'S SIGNATURE																			

00000

RECEIVED

00000

850-30-518

110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-1-68
30M 11-1-68

00696		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00691			
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Pheobe EXPENSE			Middle Anna Last Murray			2a. DATE OF DEATH Month Jan. Day 3 Year 1969		2b. HOUR 1:30 A M	
3. SEX female		4. RACE white		5. DATE OF BIRTH Sept. 16, 1876		6. AGE (In years last birthday) 92 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH New Windsor		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Horton Boarding Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Store			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Rochester, N.Y.		13b. COUNTY unknown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER unknown			
14. FATHER'S NAME First Richard Middle McGovern Last McGovern			15. MOTHER'S MAIDEN NAME First Aliza Middle Lambert Last Lambert						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 114-18-9579		17. INFORMANT Bethesda, Md.		17. INFORMANT Richard W. Murray, U.S.N. Med. Center,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic C.V.D. 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5/20/1967 to 11/3 , 19 69 , that (I) (we) last saw the deceased alive on 11/3/69 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE M. E. Robertson MD				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/3/69	
22d. PHYSICIAN'S NAME (Type) M. E. Robertson				22e. ADDRESS New Windsor, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 1/6/1969		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland			
24. FUNERAL DIRECTOR W. H. Hatcher & Sons				ADDRESS New Windsor, Md.		25a. REC'D BY REGISTRAR DATE JAN 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

1888

RECORDS OF THE

1888

RECORDS OF THE

RECORDS OF THE

RECORDS OF THE

RECORDS OF THE

RECORDS OF THE

RECORDS OF THE

RECORDS OF THE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/58

00697		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		00692	
Item 11 FilmG408 1/10/69 ts		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) First Middle Last AIVA William Nelson		2a. DATE OF DEATH Month Day Year Jan 2 1969		2b. HOUR 1:30 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Nov 26 - 1911	
6. AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Kentucky		7b. CITIZEN OF WHAT COUNTRY? USA-		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Carroll		Md.			
10. CITY OR TOWN OF DEATH Hampstead		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 217 Upper Becklesville Rd. Hampstead, Md.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer (Factory)	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Hampstead	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 217 Upper Becklesville Rd.			
14. FATHER'S NAME First Middle Last Wm Nelson		15. MOTHER'S MAIDEN NAME First Middle Last Emma			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes World War II		16b. SOCIAL SECURITY NO. 480-01-3419		17. INFORMANT Mrs. Aiva Nelson 217 Upper Becklesville Rd. Hampstead, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO, OR AS A CONSEQUENCE OF Pulmonary Emphysema Chronic Bronchitis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs 5 yrs 5 yrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from June 1955, to Jan 2 1969, that (I) (we) last saw the deceased alive on Jan 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W. H. Foard M.D.		DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) W. H. Foard MD		22c. DATE SIGNED 1/2/69			
22e. ADDRESS Manchester CT, Md 21102					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 4, 1969		23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	
23d. LOCATION (City or Town) (County) (State) Hampstead, Md.					
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead Md.		ADDRESS		25a. REGISTRAR JAN 6 1969	
25b. REGISTRAR'S SIGNATURE Charles Judge					

10022

RECEIVED IN DEPT. OF JUSTICE

10022

10022

10022

10022



10022

10022

10022

10022

10022

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
00698		00693							
1. DECEASED-NAME (Type or print) BANNIE G. PARKS				First Middle Last		2a. DATE OF DEATH Month JAN Day 17 Year 69		2b. HOUR 4:30 P M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JAN 5 1898		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL CO. Md.			
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 11 WIMERT AVE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE-WIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11 WIMERT AVE.	
14. FATHER'S NAME First DAVID Middle GREER Last				15. MOTHER'S MAIDEN NAME First MARTHA Middle SERBER Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 228-07-6895		17. INFORMANT Address MR. JIM PARKS, SAME ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hr 5 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> ot work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital), attended the deceased from 10/15 , 19 68 , to 1/17 , 19 69 , that (I) (we) last saw the deceased alive on 12/19 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Julius Chepko		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/19/69			
22d. PHYSICIAN'S NAME (Type) Julius Chepko M.D.		22e. ADDRESS 833 W. Green. Westminster, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1/20/68		23c. NAME OF CEMETERY OR CREMATORY MEADOW BRANCH		23d. LOCATION (City or Town) WESTMINSTER RD MD.		(County) (State)	
24. FUNERAL DIRECTOR K-S Meyers Jr. Westminster, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 21 1969		25b. REGISTRAR'S SIGNATURE William H. Miller			

8883

RECEIVED BY THE DIRECTOR, BUREAU OF THE ARMY, WASHINGTON, D. C.

RECEIVED BY THE DIRECTOR, BUREAU OF THE ARMY, WASHINGTON, D. C.

8883

8883

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Edward C Peregoy			2a. DATE OF DEATH JAN 18 1969			2b. HOUR 1:45 P M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH 3/27/84		6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Baltimore Co		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carmell Md.					
10. CITY OR TOWN OF DEATH Manchester, Md		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Home - 128 N. Main St		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Produce Salesman		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Baltimore		13c. CITY OR TOWN Parkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RFD 1			
14. FATHER'S NAME First Middle Last Stephen Peregoy			15. MOTHER'S MAIDEN NAME First Middle Last Sarah Bull								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. 216-30-3406		17. INFORMANT Mabel Parkton		Address 1- Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 acute Heart Failure 10 hrs DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease 5 yrs DUE TO, OR AS A CONSEQUENCE OF (c) metastatic Carcinoma 1 yr abdomen with ascites								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (1) (this hospital) attended the deceased from June 1950, to Jan 18, 1969, that (1) (we) last saw the deceased alive on Jan 18, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W.H. Foard M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-18-69					
22d. PHYSICIAN'S NAME (Type) W.H. Foard M.D.		22e. ADDRESS Manchester, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/22/69		23c. NAME OF CEMETERY OR CREMATORY Forest Baptist Cemetery		23d. LOCATION (City or Town) (County) (State) Parkton Balto. Md.					
24. FUNERAL DIRECTOR John C. Goff		ADDRESS Hampstead Md		25a. REC'D BY REGISTRAR JAN 21 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

00000

THE NATIONAL ARCHIVE

00000

Handwritten notes and signatures, including "W.H. Wood" and "J. H. Wood", are visible across the page. The text is mirrored and appears to be bleed-through from the reverse side of the document.

3 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00700		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00695			
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR a	
JAMES			ALBERT	QUARLES	1 15 69		11:00 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Male		Negro		08/15/05		63 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md
Maine		U.S.A.				CARROLL COUNTY			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Sykesville			Springfield State Hosp.			laborer			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			13b. COUNTY		Baltimore				514 Robert Street
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
HARRY			Quarles			fda			???
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				Address
no			218-05-5272		Springfield State Hospital Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>									days
4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple decubiti</u>									days
(c) <u>Generalized arteriosclerosis</u>									years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) (Pick's Disease) <u>CBS assoc. with diseases of unknown or uncertain causes with psychotic reaction</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>07/11/65</u> 19 <u>65</u> , to <u>01/15/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>01/15/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Suha Ozgun, M.D.					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/15/69		
22d. PHYSICIAN'S NAME (Type) Suha Ozgun.					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1-18-69		Arbutus Mem. PK		Arbutus, Md.			
24. FUNERAL DIRECTOR Kelson Funeral Home 1348 N. Calhoun St					25a. REC'D BY REGISTRAR DATE JAN 17 1969		25b. REGISTRAR'S SIGNATURE James J. Jones		

100 : 11

7

100

()

2

44

2

•

DISCUSSION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First Middle Last Henry Bessemer Richmond					Month Day Year 1 26 69			10A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11-19-90		6. AGE (In years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Garment Cutter		12b. KIND OF BUSINESS OR INDUSTRY Clothing		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Balto. City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 403 Notre Dame Lane	
14. FATHER'S NAME First Middle Last Henry H. Richmond					15. MOTHER'S MAIDEN NAME First Middle Last Ann Wright				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) yes		16b. SOCIAL SECURITY NO. not known		17. INFORMANT 214-01-8028		Address Springfield State Hosp. Records		Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4123</u> (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Day Years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>CBS associated with alcohol intoxication without qualifying phrase</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>11-22-68</u> , 19____, to <u>1-26-69</u> , 19____, that (I) (we) last saw the deceased alive on <u>1-26-69</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dr. Antonious Glenn</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-26-69		
22d. PHYSICIAN'S NAME (Type) Antonious Glenn, M.B.					22e. ADDRESS Sykesville, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/29/1969		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR <u>Eugene K. Seitz</u> 5209 York Rd. Seitz Funeral Home Balto. Md. 21212					25a. REC'D BY REGISTRAR JAN 28 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

00000

OFFICE OF THE

0000



JAN 2 1964

5 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
00702					00697					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
Clarence Clayton Rosier					Month 1 Day 17 Year 69			6:45 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		White		May 18, 1893		75 YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md.		U.S.A.				CARROLL Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Westminster			CARROLL Co. Hospital			Laborer		State Roads		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Carroll		Gaither		YES		Gaither Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
George - Rosier			Harriett - Dailey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			220 180378		Mrs. Nellie Rosier Gaither, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA								1 HOUR		
4109 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) ACUTE MYOCARDIAL INFARCTION								4 DAYS		
DUE TO, OR AS A CONSEQUENCE OF										
(c) ATHEROSCLEROTIC CORONARY HEART DISEASE								YEARS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1/13, 1969, to 1/17, 1969, that (I) (we) last saw the deceased alive on 1/17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					22c. DATE SIGNED					
Vincient J. Ficocco					1/17/69					
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
Vincient J. Ficocco					Westminster, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		1-20-69		Lake View Memorial		Sykesville Md.				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Harry W. Haight					DATE JAN 21 1969		J. Charles Jones			

00000

1950 10 20 11:11

00000

1950 10 20 11:11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
00703 CERTIFICATE OF DEATH 00698												
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
Adam F. Safrit						Month Day Year 1 27 69			5 16 P M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost, birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		Jan. 5, 1906			63 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Faith, N.C.		U. S.				Carroll Co., Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Westminster			Carroll Co. Gen Hospital			Blacksmith			Electric Co			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Carroll			Westminster		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 2, Box 260A, Westminster		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last									
William Lawson Safrit			Mary Yates									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address						
No			237-01-5918			Mrs. Safrit - same						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) ACUTE ANTERIOR MYOCARDIAL INFARCTION											5 DAYS	
DUE TO, OR AS A CONSEQUENCE OF												
(b) ATHEROSCLEROTIC CORONARY HEART DISEASE											YEARS	
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1/23, 1969, to 1/27, 1969, that (I) (we) last saw the deceased alive on 1/27, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			
Burial						1-29-1969			Glen Haven Memorial Pk. Glen Burnie, A.A. Co., Md.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
George I. Gonce, 4001 Ritchie Hwy., Baltimore						DATE FEB 3 1969			J. Charles Jones			

00000

RECEIVED BY MAIL

00000

RECEIVED BY MAIL

00000

00000

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 15 Film 108 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00704 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00699

1. DECEASED-NAME (Type or Print) SAMUEL CHARLES WADDELL			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 1 Day 4 Year 1969			2b. HOUR 3:10 P M		
3. SEX M	4. RACE W	5. DATE OF BIRTH JULY 22-1918	6. AGE (In years last birthday) 50 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 1 Day 4 Year 1969		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL		
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL CO. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY ORCHARD		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY CARROLL		13c. CITY OR TOWN NEW WINDSOR		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RURAL
14. FATHER'S NAME First S Middle BENJAMIN Last WADDELL			15. MOTHER'S MAIDEN NAME First EMMA Middle RUPPELHMI Last Stuller					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 215-10-5407		17. INFORMANT ADDRESS MARY WADDELL NEW WINDSOR MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed left Chest Internal Injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 917X (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6.5 MIN		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE-WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 1-4 19 69 HOUR 2:20 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Slipped & Fell from tractor				
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK OR NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) J.P. Waddell Farm		21f. LOCATION Street or R.F.D. No. Rd 1 New Windsor City or town Carroll County MD State MD				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE W Glenn Speicher			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 1-4-69		
EXAMINER'S NAME (Type) W GLENN SPEICHER			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER: <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE JAN 7-1969		23c. NAME OF CEMETERY OR CREMATORY PIPE CREEK		23d. LOCATION (City or Town) NEW WINDSOR MD County CARROLL	
24. FUNERAL DIRECTOR DD Hartzler & Sons				ADDRESS New Windsor		25a. REC'D BY REGISTRAR JAN 7 1969		25b. REGISTRAR'S SIGNATURE J Charles Jones

24300

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

CHARLES WADSWORTH

FOR THE
BUREAU

Charles Wadsworth
Bureau of Plant Industry
Washington, D. C.

Charles Wadsworth
Bureau of Plant Industry
Washington, D. C.

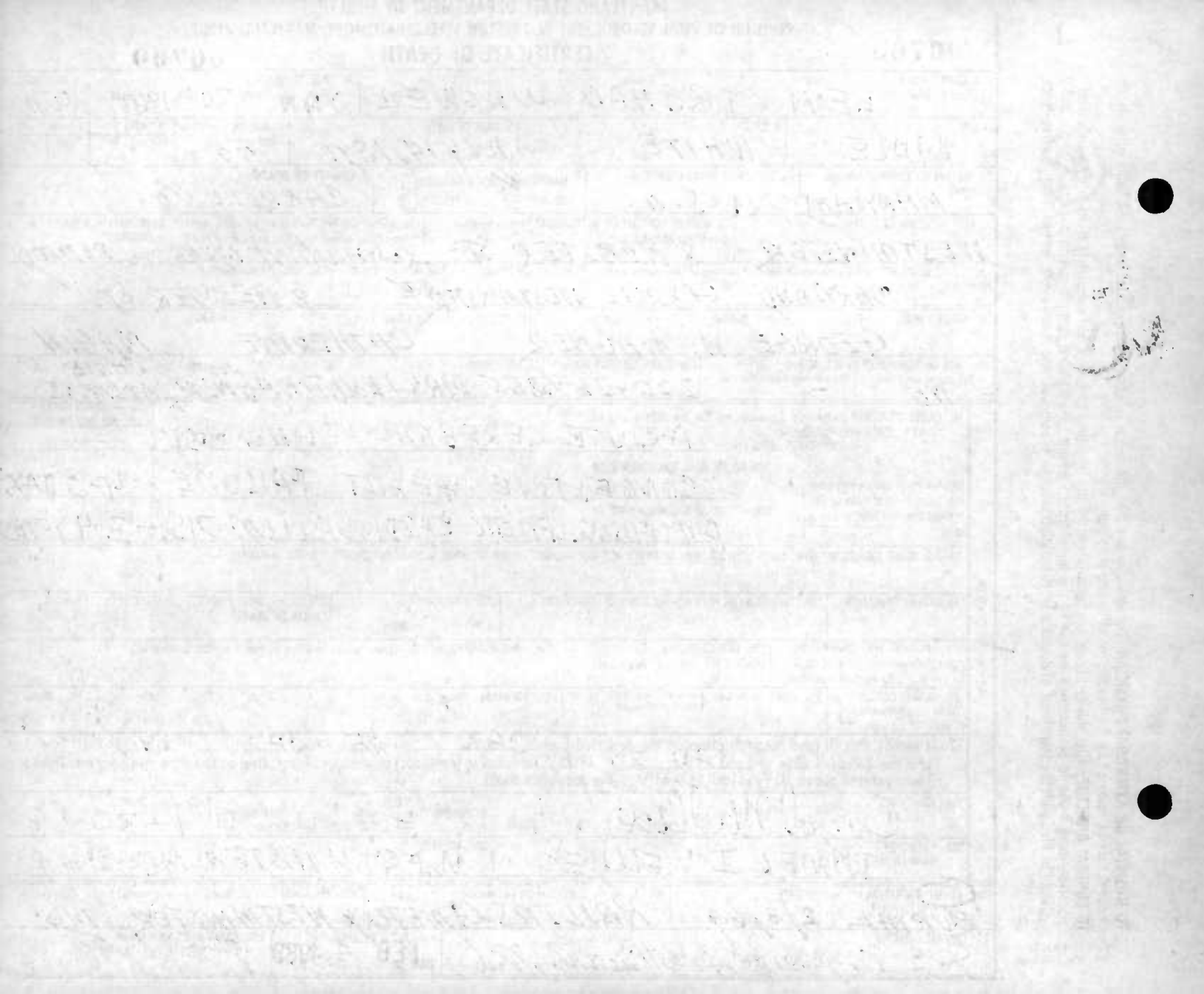
Charles Wadsworth
Bureau of Plant Industry
Washington, D. C.

1931

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
00705								00700	
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH	
LEVI TRUMAN WAGNER								JAN Month 30 Day 1969 Year	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		2b. HOUR	
MALE		WHITE		JULY 14, 1890		78 YRS.		950 M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Mo.	
MARYLAND		U.S.A.				CARROLL CO.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
WESTMINSTER		8 WEBSTER ST.		RESTAURANT OPERATOR		RETIRED			
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		CARROLL		WESTMINSTER				8 WEBSTER ST.	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
GEORGE W. WAGNER								CATHERINE MAGIN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
NO				220-26-5855		MRS LEVI T. WAGNER		SAME ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) ACUTE CEREBRAL THROMBOSIS									
412.4									
DUE TO, OR AS A CONSEQUENCE OF									
(b) CONGESTIVE HEART FAILURE								-4-5 DAYS	
DUE TO, OR AS A CONSEQUENCE OF									
(c) ARTERIOSCLEROTIC CARDIOVASCULAR DIS.								-3-4 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from JAN 1965, to JAN 1969, that (I) (we) lost saw the deceased alive on JAN 30 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE								22c. DATE SIGNED	
Daniel Welliver								1-30-69.	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
DANIEL I WELLIVER				WESTMINSTER MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		2/3/69		KRIDERS CEMETERY		WESTMINSTER MD			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
J. S. Myers, Jr., Westminster, Md.				FEB 4 1969		J. S. Myers, Jr.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) HELEN			2a. DATE OF DEATH Month Jan Day 3 Year 1969			2b. HOUR M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH OCT 24, 1907		6. AGE (In years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) M.D.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md.			
10. CITY OR TOWN OF DEATH MANCHESTER		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) LONG VIEW NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEKEEPER		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME			
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 112 BOND ST.	
14. FATHER'S NAME First ELLES Middle Last		15. MOTHER'S MAIDEN NAME First Olivia Middle Last CULLEN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) NO		16b. SOCIAL SECURITY NO. 214-28-0381		16c. INFORMANT PAUL WILDISAN		Address WESTMINSTER MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 2509 IMMEDIATE CAUSE (a) Abatement melitus c. Gangrene DUE TO, OR AS A CONSEQUENCE OF Heart (b) Arterio Sclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF Coronary Thrombosis (c) 6K0								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-6 hrs 2-3 hrs several hrs 6K0	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) OCT 19 63 CVA, Left side paralysis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 19 64 , to Jan 5, 19 69 , that (I) (we) last saw the deceased alive on Jan 5, 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE W. Glenn Speicher				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-5-69	
22d. PHYSICIAN'S NAME (Type) W. GLENN SPEICHER				22e. ADDRESS Westminster Md 21157					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JAN 8-1969		23c. NAME OF CEMETERY OR CREMATORY MEADOW BRANCH		23d. LOCATION (City or Town) (County) (State) WESTMINSTER CARROLL MD			
24. FUNERAL DIRECTOR W. C. Slaughter		ADDRESS NEW WINDSOR		25a. REC'D BY REGISTRAR JAN 9 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

10701

10701

10701

10701

10701

10701

10701

10701

10701

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00707				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00702				
1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year				2b. HOUR	
Nellie						Wilson	1-25-69				12:26 PM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		White		1-18-69			100 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				Md.	
Scotland		Balt.					Carroll					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Sykesville		Springfield State Hospital			Practical Nurse							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2606 Maryland Ave.				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last			
J.		J.		Rennie	Nellie		2		Barron			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Springfield State Hospital (Records)						
				220-51-6259								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF 4124 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years		
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 8-26-25, 19____, to 1-25-69, 19____, that (I) (we) last saw the deceased alive on 1-25-69, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Dr. Antonius Glahn, M.D.						DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-25-69		
22d. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.						22e. ADDRESS Springfield State Hospital Sykesville, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1-25-69		23c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery		23d. LOCATION (City or Town) (County) (State) Sykesville, Md.						
24. FUNERAL DIRECTOR Harry W. Haight, Sykesville, Md.						25a. REC'D BY REGISTRAR DATE JAN 28 1969		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]				

00700

00700

STATE OF CALIFORNIA

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

2000 3 1960

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00708

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00703

1. DECEASED-NAME (Type or Print) LUCILLE VIRGINIA WILT			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> EST. <input type="checkbox"/> MATED <input type="checkbox"/> Month 1-24 Year 1969			2b. HOUR 8:10 PM		
3. SEX Female	4. RACE white	5. DATE OF BIRTH 1-29-16	6. AGE (In years last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS 21 DAYS 30	IF UNDER 24 HRS. HOURS 12 MIN. 00	2c. DATE PRONOUNCED DEAD Month 1 Day 24 Year 1969		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll		
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife/Tile Clerk		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME William Cullum			15. MOTHER'S MAIDEN NAME Julia Hasley			13e. STREET AND NUMBER 509 E. 35th St.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. 211-30-2562			17. INFORMANT Records- Springfield State Hospital		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary Artery Embolism 450x DUE TO, OR AS A CONSEQUENCE OF Site of origin unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Schizophrenic reaction, chronic undifferentiated type.								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE W. Glenn Speicher			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 1-25-69		
EXAMINER'S NAME (Type) W. Glenn Speicher, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 1/28/1969			23c. NAME OF CEMETERY OR CREMATORY Southern Cemetery		
24. FUNERAL DIRECTOR Mitchell - Weddell			ADDRESS 6500 York Rd. Home			23d. LOCATION (City or Town) (County) (State) Dublin Md		
25a. REC'D BY REGISTRAR DATE JAN 30 1969			25b. REGISTRAR'S SIGNATURE Charles Judge					

10705

10705

RECEIVED

RECEIVED

RECEIVED

10705

RECEIVED

RECEIVED

RECEIVED

10705

RECEIVED

RECEIVED